MEDI-CAL UPDATE Part 2
Billing and Policy
www.medi-cal.ca.gov

Medical Services • General Medicine

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Contents

Medi-Cal Claim Form Changes May 23, 2007; Transition from Current Form Begins March 26

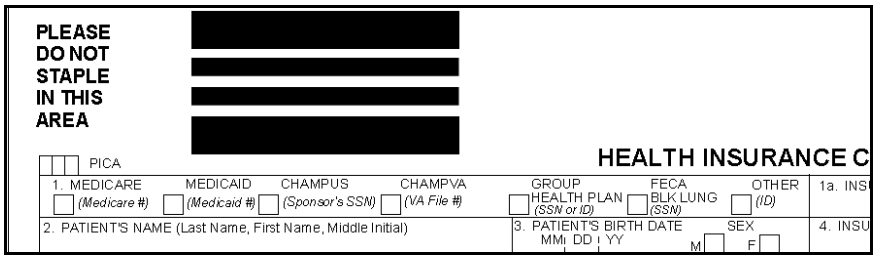
Effective May 23, 2007, the California Department of Health Services (CDHS) will complete a transition from the current *HCFA 1500* claim form to the new *CMS-1500* claim form. Beginning March 26, 2007, providers will have a two-month transition period in which they can use both the new and old form to submit claims. The transition period ends at the close of business on May 22, 2007. Beginning May 23, 2007, only the *CMS-1500* will be accepted for Medi-Cal billing.

All boxes mentioned below are only updates to the new form. Not all new and updated boxes must be filled in for proper billing and payment. New claim form billing instructions will be published in the appropriate Part 2 provider manual in May 2007.

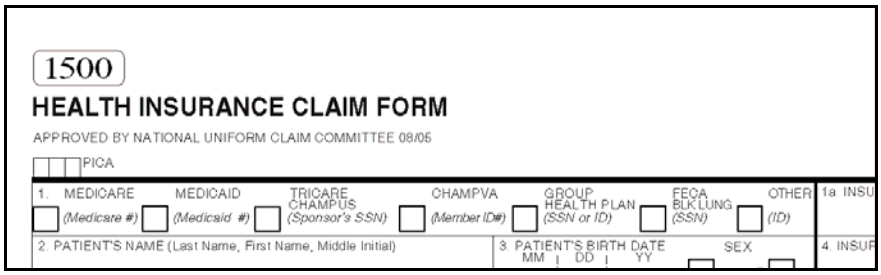
Also, providers using the new forms must continue to use their Medi-Cal provider number until May 23, 2007.

Below are the changes from the current *HCFA 1500* to the new *CMS-1500* claim form.

Header and Box 1:
Old Form



New Form

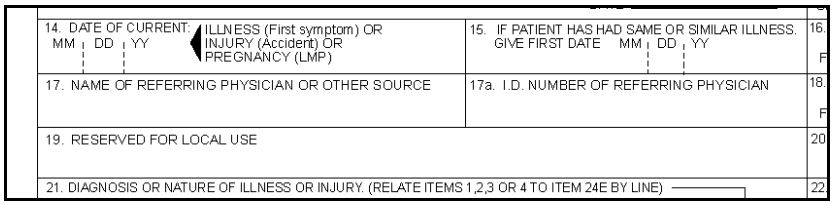


At the top of the page: 1) the barcode has been removed, 2) the language "Please Do Not Staple In This Area" has been removed, and 3) a box with "1500" is added in black ink. In Box 1, "Tricare" was added above "Champus."

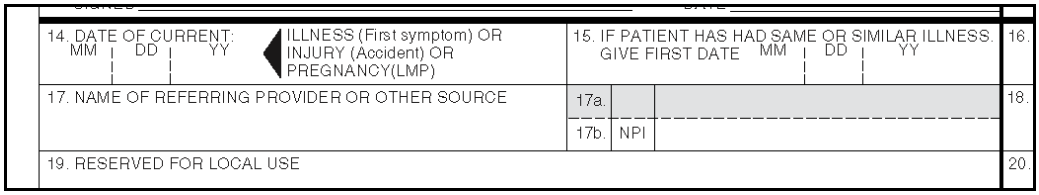
Please see **Claim Form**, *page 2*

Claim Form *(continued)*

Box 17
Old Form

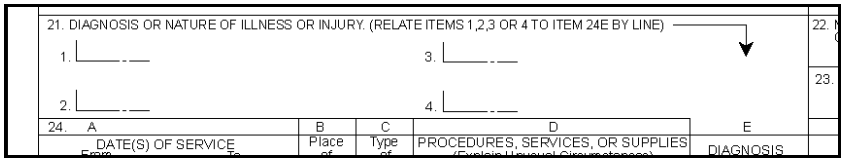


New Form

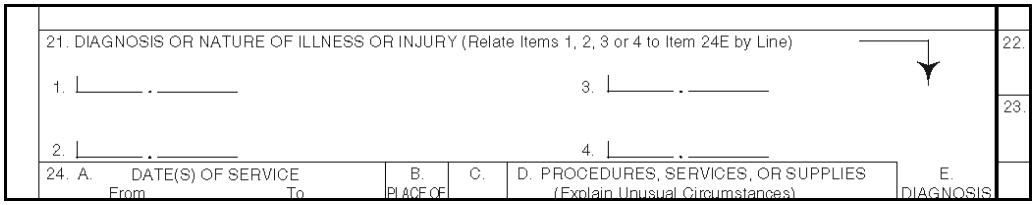


The name of Box 17 was changed to "Name of Referring **Provider** or Other Source." Box 17A ("ID Number of Referring Physician") was removed. The *NPI* field (Box 17B) was added.

Box 21 (Diagnosis of Illness or Injury)
Old Form



New Form

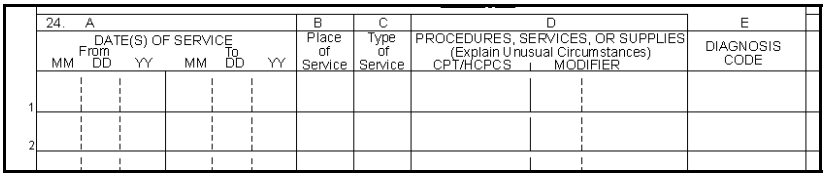


The spaces after the decimal point in items 1, 2, 3 and 4 were extended to accommodate future changes in diagnosis codes.

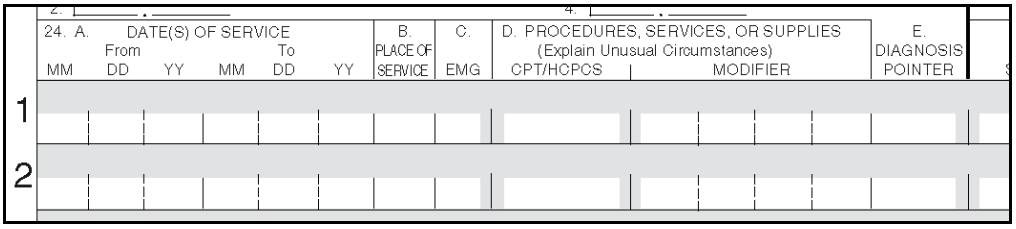
Please see **Claim Form**, *page 3*

Claim Form *(continued)*

Boxes 24A – 24E
Old Form

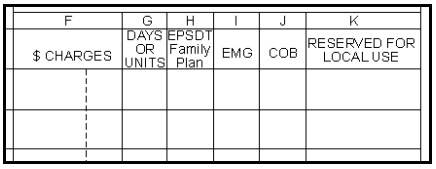


New Form

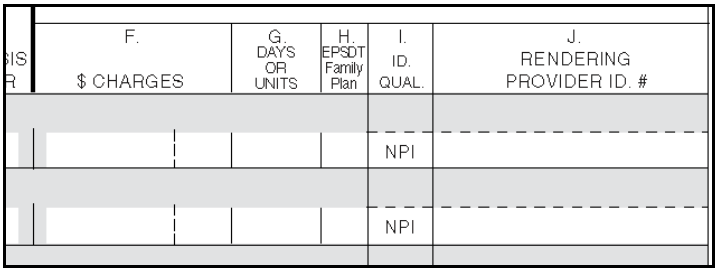


The lines are split length-wise, with shading added to the top portion of each line. The shaded area is used for the reporting of supplemental information. Information submitted in the shaded area must stay within the shaded area to process correctly. The name of Box 24C was changed to "EMG." This is the new location for emergency and delay reason codes.

Boxes 24I – 24K
Old Form



New Form

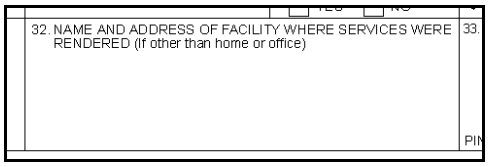


The name of Box 24I was changed to "ID Qual." The name of Box 24J was changed to "Rendering Provider ID #" and the unshaded area was named "NPI." The rendering provider's National Provider Identifier (NPI) must be reported in the unshaded box. Also, Box 24K ("Reserved for Local Use") was removed.

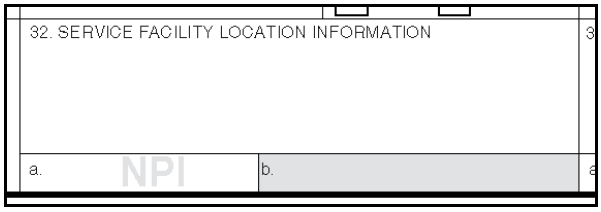
Please see **Claim Form**, *page 4*

Claim Form *(continued)*

Box 32
Old Form



New Form



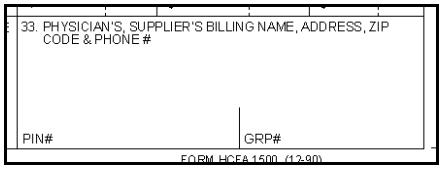
Box 32 was renamed "Service Facility Location Information." Boxes 32A and 32B were added at the bottom. Box 32A was added to accommodate reporting of the facility NPI. Box 32B was added to accommodate reporting of an "atypical" facility provider number.

Note About Atypical Providers:
In accordance with the NPI final rule, some providers may not qualify for an NPI and therefore are not required to register an NPI with the Medi-Cal program. According to CDHS' interpretation of the final rule as it relates to atypical providers, the following Medi-Cal provider types below are <u>not</u> required to register an NPI:

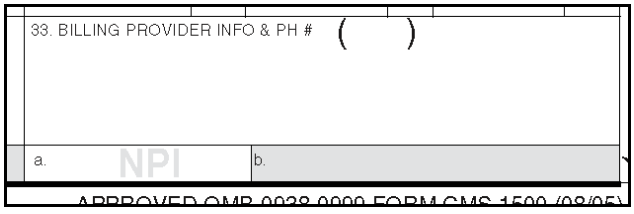
- Adult Day Health Care (ADHC) Centers
- Blood Banks
- Christian Science Practitioner
- Multipurpose Senior Services Program (MSSP)

If any of the above provider types acquire an NPI, they may register it with the Medi-Cal program, but it is not required.

Box 33
Old Form



New Form



Box 33 was renamed "Billing Provider Info & Phone Number." Boxes 33A and 33B were added at the bottom. Box 33A was added to accommodate reporting of the billing provider's NPI. Box 33B was added to accommodate reporting of an atypical provider number.

Family PACT Formulary Update

Effective for dates of service on or after January 16, 2007, Family PACT (Planning, Access, Care and Treatment) is adding oral contraceptive pills to the Family PACT Pharmacy Formulary for dispensing by pharmacies and clinicians. Clinicians must bill these contraceptives using HCPCS code X7706 (oral contraceptive medication).

The following drugs and strengths are added as Family PACT Pharmacy Formulary benefits for Pharmacy providers and clinicians:

- Drospirenone/Ethinyl Estradiol (Yaz tablets) – The 28-day treatment cycle consists of 24 active tablets, each containing 3 mg of drospirenone and 0.02 mg of ethinyl estradiol, as well as four inert tablets.
- Norethindrone/Ethinyl Estradiol/Ferrous Fumarate (Femcon 35 Fe chewable tablets) – The 28-day treatment cycle consists of 21 tablets, each containing 0.4 mg of norethindrone and 0.035 mg of ethinyl estradiol, as well as seven placebo tablets, each containing 75 mg of ferrous fumarate.
- Norethindrone Acetate/Ethinyl Estradiol/Ferrous Fumarate (Loestrin 24 Fe) – The 28-day treatment cycle consists of 24 tablets, each containing 1 mg of norethindrone acetate and 0.02 mg of ethinyl estradiol, as well as four placebo tablets, each containing 75 mg of ferrous fumarate.

The following contraceptive has been added as a Family PACT benefit and may be dispensed by Pharmacy providers only:

- Levonorgestrel/Ethinyl Estradiol (Seasonique tablets) – The 91-day treatment cycle consists of 84 active tablets, each containing 0.15 mg of levonorgestrel and 0.03 mg of ethinyl estradiol, as well as seven tablets, each containing 0.01 mg of ethinyl estradiol.

Revised *Family PACT Policies, Procedures and Billing Instructions* (PPBI) manual pages will be issued in a future mailing to Family PACT providers. For more information about Family PACT, call the Telephone Service Center (TSC) at 1-800-541-5555 from 8 a.m. to 5 p.m. Monday through Friday, except holidays, or visit the Family PACT Web site at **www.familypact.org**.

Annual Family PACT Updates and Policy Clarification

Effective for dates of service on or after February 1, 2007, the following CPT-4 code information is updated to reflect current Family PACT Program policy. These updates affect billing requirements and restrictions but do not expand program benefits.

CPT-4 Code Additions

The following CPT-4 codes are added to the Family PACT Program:

Code	Description
58110	Endometrial sampling (biopsy) done in conjunction with colposcopy
78456	Acute venous thrombosis imaging
90760	Intravenous infusion, hydration, up to one hour
90761	Intravenous infusion, additional hours
99144	Moderate sedation, first 30 minutes
99145	Moderate sedation, each additional 15 minutes

Please see **Family PACT**, *page 6*

Family PACT *(continued)*

CPT-4 Code Restriction Modifications
Code 58110 is restricted to females 15 to 55 years of age when clinically indicated for the follow-up of a Pap smear result finding atypical glandular cells (ICD-9-CM code 795.00) and any of the following:

- Atypical endometrial cells, or
- A recent history of abnormal vaginal bleeding pattern suspicious for endometrial hyperplasia or cancer, or
- Recipient is 36 to 55 years of age

This procedure is reimbursable to non-physician medical practitioners. The procedure is payable for all primary diagnosis codes except S60 and S80. A secondary diagnosis code of 795.00 is required or the claim will deny.

Code 78456 is restricted to females. A primary diagnosis code of S1031 and an approved *Treatment Authorization Request* (TAR) are required or the claim will deny.

Codes 90760 and 90761 are restricted to females. The procedure is payable only for primary diagnosis code S2031 or S3035 and requires an approved TAR. The claim must include documentation that a physician administered or supervised the procedure.

Code 99144 is restricted to females 21 to 55 years of age with a primary diagnosis code of S702 and to males 21 to 60 years of age with a primary diagnosis code of S802.

Code 99145 is billed only in conjunction with 99144. It is restricted to females 21 to 55 years of age with a primary diagnosis code of S702 and to males 21 to 60 years of age with a primary diagnosis code of S802.

Code 58100 (endometrial sampling, with or without endocervical sampling, without cervical dilatation, any method, separate procedure) is restricted to females 40 to 55 years of age with a finding of endometrial cells on Pap and a recent history of menstrual irregularity. A secondary diagnosis of 795.09 (other abnormal Pap) is required on the claim or the claim will deny.

CPT-4 Code Deletions
Codes 78455, 90780, 90781 and 99141 are no longer active and are deleted as Family PACT Program benefits.

"Family PACT Program 2006 Provisional Clinical Services Benefits Grid"
The "Family PACT Program 2006 Provisional Clinical Services Benefits Grid" presents the benefits package codes for procedures, medications and contraceptive supplies. Code 58110 is added to the benefits package effective February 1, 2007.

The following information replaces the 9th page of the Family PACT Provisional Services Benefits Grid (see June 2006 *Medi-Cal Update* Part 2 bulletin). The bulletin page number to be replaced will vary depending on which bulletin the provider received.

Please see **Family PACT**, *page 7*

Family PACT *(continued)*

Secondary Diagnosis: Cervical Abnormalities

A secondary diagnosis code is required for cervical abnormality diagnostic and treatment services. These services are restricted to females 15 to 55 years of age.

Other Secondary Services						Complications Services (10)
Diagnosis Codes	**Description**	**Procedures**	**Laboratory**	**Supplies**	**Medications**	**Description**
ICD-9-CM 795.01 795.02 795.03 795.04 795.05 622.2	 ASC-US Pap ASC-H Pap LGSIL Pap HGSIL Pap Abn Pap with HPV high risk pos. Presumptive Dx. Leukoplakia, cervix	57452 Colposcopy 57454 Colpo with biopsy & ECC 57455 Colpo with biopsy 57456 Colpo with ECC	• 87621 DNA Amplified Probe HPV High Risk Only (18) • 88305 Surgical pathology	57452ZM Supplies 57454ZM Supplies 57455ZM Supplies 57456ZM Supplies	None	Pelvic infection resulting from cervical treatment Hemorrhage from cervical biopsy or treatment site requiring surgical repair Vaso-vagal episode
795.00	AGC Pap	57452 Colposcopy 57454 Colpo with biopsy & ECC 57455 Colpo with biopsy 57456 Colpo with ECC 58110 Endometrial biopsy (19)	• 88305 Surgical pathology	57452ZM Supplies 57454ZM Supplies 57455ZM Supplies 57456ZM Supplies 58100ZM Supplies	None	
622.11 622.12 233.1	CIN I (biopsy) CIN II (biopsy) CIN III (biopsy)	57452 Colposcopy 57454 Colpo with biopsy & ECC 57455 Colpo with biopsy 57456 Colpo with ECC 57511 Cryocautery of cervix (16) 57460 LEEP (16)	• 87621 DNA Amplified Probe HPV High Risk Only (18) • 88305 Surgical pathology • 88307 Surgical pathology (17)	57452ZM Supplies 57454ZM Supplies 57455ZM Supplies 57456ZM Supplies 57511ZM Supplies 57460ZM Supplies	None	
795.09	Other abnormal Pap	58100 Endometrial biopsy (20)	• 88305 Surgical pathology			

(10) Complication services for a secondary diagnosis require a primary diagnosis (Sxx.3) and a TAR – see *Family PACT: Treatment Authorization Request (TAR).*

(16) Restricted to biopsy proven CIN II or CIN III or persistent CIN I lesions of greater than 12 months.

(17) Restricted to biopsy specimens collected by LEEP procedure.

(18) DNA Amplified Probe HPV (High Risk Only) is covered in the following circumstances (see ASCCP, Guidelines 2002) and limited to one per year per client:

- Reflex HPV DNA testing after an ASC-US cytology result.
- Follow-up of LSIL cytology result in women less than 21 years of age. HPV DNA testing at 12 months in lieu of cytology at 6 and 12 months.
- Follow-up post-colposcopy; Women with Paps read as ASC-H, LSIL, or HPV DNA positive ASC-US in whom CIN is not identified at colposcopy can be followed up at 12 months with HPV DNA testing in lieu of cytology at 6 and 12 months.
- Follow-up of women with biopsy proven untreated CIN I; HPV DNA testing at 12 months in lieu of cytology at 6 and 12 months.
- Follow-up post treatment of CIN II, III: HPV DNA test at least six months after treatment in lieu of follow-up cytology.

DNA Amplified Probe HPV testing is not covered for a diagnosis of HGSIL Pap, ICD-9-CM 795.04 or Leukoplakia cervix, ICD-9-CM 622.2.

(19) Endometrial biopsy is covered only if AGC (atypical glandular cells) cytology result and any of:

- "Atypical endometrial cells" on AGC cytology result.
- Woman is having abnormal vaginal bleeding pattern suspicious for endometrial hyperplasia or cancer.
- Woman is 36 through 55 years of age.

(20) Endometrial biopsy restricted to women aged 40 years or older with a finding of endometrial cells on Pap and a recent history of menstrual irregularity.

Please see **Family PACT**, *page 8*

Family PACT *(continued)*

Family PACT Formulary Update
The following policy clarifications correct errors in the printed version of the Family PACT Pharmacy Formulary only. Online adjudication of pharmacy claims is not affected.

The following formulations are not available:

- Norethindrone and ethinyl estradiol 1 mg – 20 mcg tablets from 28 tablet pack
- Norethindrone and ethinyl estradiol 1.5 mg – 30 mcg tablets from 28 tablet pack

Corrected dosage information:

- Norelgestromin and ethinyl estradiol Transdermal Patch is 0.15mg/20mcg/day.
- Etonorgestrel and ethinyl estradiol Vaginal Ring is 0.120mg/15mcg/day.

Permanent Contraception (Sterilization) Policy Clarifications
Postoperative core services refer to the routine care associated with a surgical procedure, including routine postoperative care. Services for the management of complications are not core services. Related reproductive health services are not routine postoperative care. This policy applies to services for both female and male recipients.

Postoperative core services are provided during the global period defined for the surgical procedure. The global period is 90 days for surgical procedure codes 55250, 58600, 58615, 58670 and 58671.

At the end of the 90-day post-operative period, or earlier as determined by the clinician, sterilized clients are no longer eligible for the Family PACT Program. This clarification applies to both female and male recipients that have elected permanent contraception.

Revised *Family PACT Policies, Procedures and Billing Instructions* (PPBI) manual pages will be issued in a future mailing to Family PACT providers. For more information about Family PACT, call the Telephone Service Center (TSC) at 1-800-541-5555 from 8 a.m. to 5 p.m. Monday through Friday, except holidays, or visit the Family PACT Web site at **www.familypact.org**.

Capsule Endoscopy Split-Billing Reimbursement Policy Update

Effective for dates of service on or after February 1, 2007, the split-bill reimbursement for the professional component of CPT-4 code 91110 (gastrointestinal tract imaging, intraluminal [eg, capsule endoscopy], esophagus through ileum, with physician interpretation and report) will change from 85 to 15 percent.

Claims for code 91110 must be billed with modifier 26, TC or ZS, and require prior authorization. Information about reimbursement rates can be found on the Medi-Cal Web site (**www.medi-cal.ca.gov**) by clicking "Medi-Cal Rates" under the "Provider Reference" heading.

Plan B Update

On August 26, 2006, the federal Food and Drug Administration (FDA) announced the approval of the emergency contraceptive drug Plan B as being over-the-counter (OTC) for women 18 years of age or older. Though the FDA has removed the prescription requirement as noted, access to Plan B as a covered drug through the fee-for service Medi-Cal program will continue to require a prescription for all recipients due to restrictions in federal Medicaid drug coverage statutes (Social Security Act, Section 1927).

The federal Medicaid requirement for a prescription is met by a prescription generated by a pharmacist pursuant to standardized procedures or protocols developed by the pharmacist and an authorized prescriber, who is acting within his or her scope of practice, or the standardized procedures or protocols established by the California Board of Pharmacy pursuant to *Business and Professions Code* (B&P Code), Section 4052.

The statewide standardized protocol and information regarding the dispensing of emergency contraception under protocol can be obtained from the Board of Pharmacy Web site at:
www.pharmacy.ca.gov/consumers/emergency_cont.htm.

Termination of Intrauterine Device (IUD) – Code X1512

Effective for dates of service on or after February 1, 2007, HCPCS Level III code X1512 (CU-7, Lippes Loop® or unspecified IUD) is no longer reimbursable.

Codes X1522 (ParaGard®) and X1532 (Mirena Intrauterine System®) remain benefits for IUD devices.

This information is reflected on manual replacement pages fam planning 7 (Part 2) and non ph 11 (Part 2).

Updated Benefit Status of Select Drug and Medicine Codes

Effective February 1, 2007, HCPCS code J3490 (unclassified drugs) is a Medi-Cal benefit and should be used instead of CPT-4 codes 90399 and 90749. Effective February 1, 2007, CPT-4 codes 90399 (unlisted immune globulin) and 90749 (unlisted vaccine/toxoid) are no longer benefits.

HCPCS code J3490 is to be reimbursed "By Report" and an invoice is required. When billing code J3490, providers must include a diagnosis code and document the following in the *Reserved for Local Use* field (Box 19) of the claim:

- Medical necessity for using the drug
- Name, dosage, strength and unit price of the medication

HCPCS code J3590 (unclassified biologics) requires a *Treatment Authorization Request* (TAR) and must be billed with an invoice for pricing. Providers must also document the following on the TAR:

- Medical necessity for using the drug
- Name, dosage, strength and unit price of the medication

Note: Providers should use codes J3490 and J3590 only if an appropriate injection code is not found.

This information is reflected on manual replacement pages inject 2 and 3 (Part 2), inject list 9 and 18 (Part 2), non ph 5 and 11 (Part 2) and tar and non cd9 1 (Part 2).

Synagis Guidelines Revisions

In October 2006, the American Academy of Pediatrics published "Guidelines for Bronchiolitis," which revised the previous guidelines for Synagis. The updated information, effective immediately, is as follows.

Dosage
The Respiratory Syncytial Virus (RSV) season generally occurs during the months of November through March. The severity, onset, peak and end of season cannot be predicted accurately. In a typical season, children receive five monthly doses of Synagis, beginning early in November. For children meeting the guidelines, up to six doses may be authorized for use between October and the following May. Once a child qualifies for initiation of prophylaxis, administration should continue throughout the season and not stop at the point an infant reaches an age cutoff.

Please see **Synagis**, *page 10*

Synagis *(continued)*

Risk Categories
It is important to protect babies at high risk, who fall into three major categories:

- Chronic lung disease and less than 24 months old at the start of the RSV season, especially those who have received oxygen or medications within six months of the start of the RSV season.
- Prematurity
  - Born at 28 weeks gestation or less, first RSV season, less than 12 months of age at the start of the season
  - Born between 29 and 32 weeks gestation, first RSV season, less than 6 months of age at the start of the season
  - Born at 32 – 35 weeks gestation, less than 6 months of age at the start of the season with two or more of the risk factors below:
    - ❖ child care attendance
    - ❖ school-aged children in the home
    - ❖ environmental air pollutants, including second-hand tobacco smoke
    - ❖ congenital abnormalities of the airways
    - ❖ severe neuromuscular disease
- Congenital heart disease and less than 24 months old at the start of the RSV season, especially those on medication for congestive heart failure, or those with pulmonary hypertension or cyanosis

Children with severe immune deficiency (for example, severe combined immunodeficiency, acquired immunodeficiency syndrome, transplant recipients or children immunocompromised due to chemotherapy) may need prophylaxis, including another season or more, up to 48 months of age at the start of RSV season.

This information is reflected on manual replacement pages inject 9 and 10 (Part 2).

CPT-4 Code 13101 – Reimbursement Restriction

Effective for dates of service on or after February 1, 2007, CPT-4 code 13101 (repair, complex, trunk; 2.6 cm to 7.5 cm) is no longer reimbursable for assistant surgeon services.

This information is reflected on manual replacement page tar and non cd1 3 (Part 2).

Therapeutic Injection Benefits Update

Effective for dates of service on or after February 1, 2007, the following CPT-4 codes are Medi-Cal benefits:

CPT-4 Code	Description
90773	Therapeutic, prophylactic or diagnostic injections (specify substance or drug); intra-arterial
90774	intravenous push, single or initial substance/drug
90775	each additional sequential intravenous push of a new substance/drug

Providers may bill for CPT-4 code 90775 in conjunction with codes 90765, 90774, 96409 and 96413.

This information is reflected on manual replacement pages inject 4 (Part 2) and tar and non cd9 1 (Part 2).

Expanded Coverage for Docetaxel Reimbursement

Effective February 1, 2007, reimbursement for HCPCS code X7638 (docetaxel) will be expanded to include the following ICD-9-CM diagnosis codes:

ICD-9-CM Diagnosis Code	Description
151.2 – 151.9	Malignant neoplasm of stomach
188.1 – 188.4, 188.9	Malignant neoplasm of bladder

This information is reflected on manual replacement page chemo 18 (Part 2).

CPT-4 Code 87904 Policy Change

Effective February 1, 2007, the number of daily units that may be reimbursed for CPT-4 code 87904 (infectious agent phenotype analysis by nucleic acid [DNA or RNA] with drug resistance tissue culture analysis, HIV 1; each additional drug tested) has been increased to 10 drug tests per day for the same patient, same provider and same date of service.

This information is reflected on manual replacement pages path micro 4 (Part 2) and tar and non cd8 1 (Part 2).

HCPCS Code S3625 Rate Update

Effective January 1, 2007, the rate for HCPCS code S3625 (Maternal Serum Multiple Marker [MSMM], including Alpha-Fetoprotein [AFP], estriol and human Chorionic Gonadotropin [hCG]) has increased from $105 to $155. This rate change is in accordance with Senate Bill 155.

Medi-Cal List of Contract Drugs

The following provider manual sections have been updated: *Drugs: Contract Drugs List Part 1 – Prescription Drugs* and *Drugs: Contract Drugs List Part 2 – Over-the-Counter Drugs.*

Addition, effective January 1, 2007

Drug	Size and/or Strength
* LEVONORGESTREL	
Tablets	0.75 mg
* Restricted to a maximum quantity of two tablets per dispensing with a maximum of six dispensings in any 12-month period for females 18 years of age and older.	

Please see **Contract Drugs**, *page 12*

Contract Drugs *(continued)*

Changes, effective January 1, 2007

Drug	**Size and/or Strength**	
* AMPHETAMINE, MIXED SALTS (AMPHETAMINE SULFATE, AMPHETAMINE ASPARTATE, DEXTROAMPHETAMINE SULFATE AND DEXTROAMPHETAMINE SACCHARATE)		
Tablets	5 mg	
	7.5 mg	
	10 mg	
	12.5 mg	
	15 mg	
	20 mg	
	30 mg	
~~**(Labeler Code 54092 and 58521 [Shire US, Inc.] only.)**~~		
Capsules, extended release	5 mg	
	10 mg	
	15 mg	
	20 mg	
	25 mg	
	30 mg	
* Restricted to use in Attention Deficit Disorder individuals between 4 and 16 years of age.		
BRIMONIDINE TARTRATE		
Ophthalmic solution	0.15 %	
	0.1 %	
	0.2 % *	
* ~~Prior authorization always required.~~ **Restricted to claims submitted with dates of service from October 1, 1997 through July 31, 2005.**		
GATIFLOXACIN		
Ophthalmic solution	**0.3 %**	
KETOROLAC TROMETHAMINE		
Ophthalmic solution	**0.4 %**	
	0.5 %	
TRAVOPROST		
Ophthalmic solution	0.004 %	2.5 cc
		5.0 cc
Ophthalmic solution with Sofzia preservative	**0.004 %**	**2.5 cc**
		5.0 cc

Please see **Contract Drugs**, *page 13*

Contract Drugs *(continued)*

Change, effective March 1, 2007

Drug	**Size and/or Strength**
CLARITHROMYCIN	
* Tablets, extended release	200 mg
(NDC labeler code 00074 [Abbott Laboratories] for extended release tablets.)	
* Tablets	250 mg
	500 mg
* **Restricted to use in the prevention and treatment of infections caused by Mycobacterium organisms, and in the treatment of active duodenal ulcer associated with Heliobacter pylori.**	
* Liquid	125 mg/5cc
	250 mg/5cc
* Restricted to use in the prevention and treatment of infections caused by Mycobacterium organisms, and in the treatment of active duodenal ulcer associated with Helicobacter pylori **and restricted to NDC labeler code 00074 [Abbott Laboratories] for liquid.**	

Instructions for Manual Replacement Pages — Part 2

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Remove and replace:	*Contents for GM Billing and Policy* vii/viii * chemo 17/18 fam planning 7/8 inject 1 thru 4, 9 thru 12 inject list 9/10, 17/18 non ph 3/4 *, 5/6, 11/12 path micro 3/4 presum 17/18 *
Insert new section after the *Why You Cannot Get Presumptive Eligibility Benefits* form:	prov bil 1 thru 4 *
Insert after the new *Provider Billing after Beneficiary Reimbursement (Conlan v. Shewry)* section above:	*Request for Beneficiary Reimbursement Letter (Letter 08)* *
Remove and replace:	tar and non cd1 3/4 tar and non cd8 1/2 tar and non cd9 1/2

* Pages updated due to ongoing provider manual revisions.